NeuroCare Center
4105 Holiday Street, NW Canton, OH 44718
330-494-2097 • 800-520-5695

REFERRAL REQUEST
Fax 330-966-5523

Patient's Name _____ DOB _____

Parent or guardian's name (if minor) _____

Insurance _____
(Please fax a copy of both front & back of insurance card with this form)
ID #_____Group #_____

Home Phone # _____ Cell Phone # _____

Home Address _____

Diagnosis _____

Degree of Urgency:
Routine _____ Urgent* _____ See within _____ days
*** Referrals marked as Urgent will be seen by the first available physician within 7-10 days.**

Do you have a physician preference? _____
(If not available, we will contact you to offer an appointment with another physician.)

Office Preference:
Canton _____ Alliance _____ Orrville _____

For:
_____ Consultation _____ Routine EEG _____ EMG
_____ MRI _____ Sleep EEG _____ Upper extremity L / R / B
_____ Carotid Ultrasound _____ VNG _____ Lower extremity L / R / B

_____ Other _____

Referring physician name & signature_____

Contact person _____

Office phone number _____ Office fax number _____

Please fax a copy of the patient's insurance card, demographics and any pertinent medical information including office notes and recent test results with this referral request.